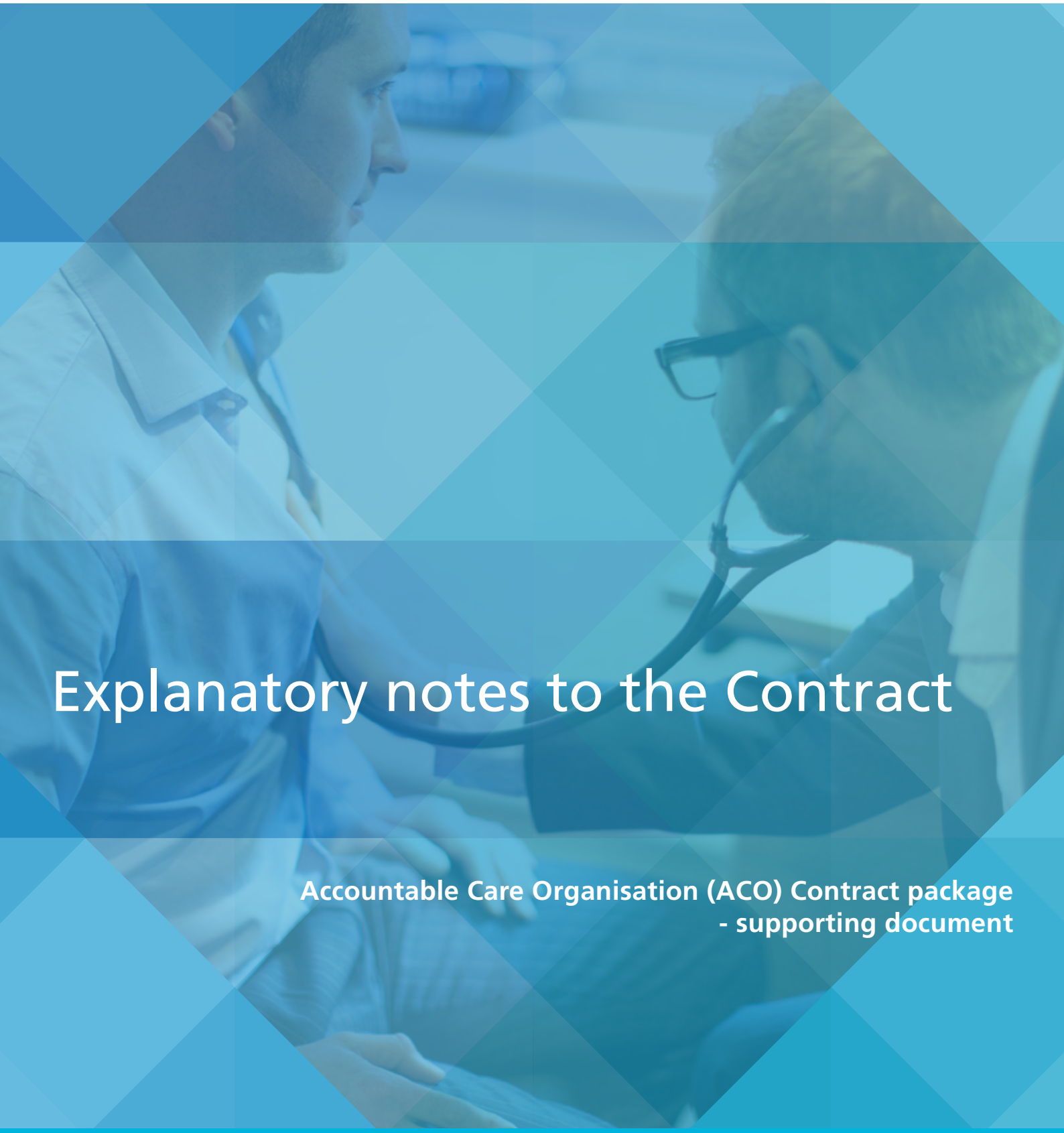
New care models



Explanatory notes to the Contract

Accountable Care Organisation (ACO) Contract package - supporting document

Our values:
clinical engagement, patient involvement, local ownership, national support

August 2017

Explanatory notes to the Contract

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Equality and health inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Introduction

1 This document describes the proposed structure and content of the Contract for accountable models of care on a section-by-section basis.

Overall content and structure of the ACO Contract

2 At the moment, NHS commissioners must use different contractual forms for primary care (for which GMS, PMS and APMS contracts are mandated through specific regulations and directions) and for hospital and community health services (where NHS England's Standing Rules Regulations enable us to publish, and mandate use of, the NHS Standard Contract). But at the heart of an accountable care model is the integration between general practice and other community services – so a new type of contract, different from existing forms, is needed to commission integrated services from an Accountable Care Organisation (ACO).

3 In developing the Contract, we identified at an early stage that the existing legal requirements for primary care contracts, particularly as set out in the current APMS Directions (many of which are derived from PMS Regulations), were – with the MCP and PACS models in mind – unnecessary or excessively detailed in certain respects and inappropriate in others. The Department of Health (DH) has now drafted a revised set of Directions relating to contracts for accountable care, which are expected to be published in final form later in the year. We have updated the Contract to refer to the new Directions as currently drafted by DH, but further iteration will be required to reflect the final version when published. Appendix 1 provides further explanation of what provisions specific to primary medical care have been included in the Contract at this stage.

4 Against this background, the nationally-mandated content of the Contract can be seen as being derived from four key sources:

- **existing** provisions from the generic NHS Standard Contract, which we believe are essential requirements which must be retained in the Contract (NHS Constitution standards, for example, as well as national policy priorities and essential contract management processes);
- **simplified** requirements produced by merging an existing NHS Standard Contract requirement and requirements of new draft (unpublished) directions relating to ACO Contracts, (the latter generally reflecting existing PMS requirements):requirements on training of staff, for instance, and confidentiality of information;
- **revised** provisions (indicative only at this stage) specific to primary medical services, based on new draft (unpublished) Directions relating to ACO Contracts (again, generally reflecting existing PMS requirements);
- **new** requirements specific to an accountable (MCP or PACS) care model (improving population health, for instance, addressing health inequalities, providing seamless, integrated person-centred care, putting in place effective strategies for patient activation, developing shared electronic patient records).

5 Alongside these core nationally-mandated provisions, the Contract includes schedules which are for local completion. To reflect this, the Contract (in line with the generic NHS Standard Contract) is structured in three parts:

- **Service Conditions**, setting out the core requirements in clinical and service terms which any ACO will be required to deliver;
- **General Conditions**, setting out the necessary contract management processes and standard, legal 'boilerplate' requirements; and
- **Particulars**, which record the signature of the contract and contain all the locally-agreed schedules.

6 The nationally-mandated provisions of the Contract will be locally adaptable in three respects.

- A slightly different mix of provisions will apply depending on whether the ACO is operating under the 'fully-integrated' or 'partially-integrated' model. For the former, provisions will be included relating to core primary medical services, including operation of the patient list; for the latter, the Contract will exclude provisions relating solely to core primary medical services, and will instead make reference to the obligations of the ACO in relation to the **integration** of its (community) services with core primary medical services (for the delivery of which practices will remain responsible). Colour-coding within the Contract sets out how this tailoring is likely to operate.
- We understand that some CCGs will be considering a scenario where they will end up with a "mixed economy" of practices, with some opting to relate in a partially integrated way, and some in a fully integrated way. The Contract does not attempt to provide for such a "mixed economy", but we anticipate that with further development (as a co-production with CCGs envisaging this scenario) it will be possible to accommodate it. This is likely to involve, for example, distinguishing certain provisions which apply only in respect of some services/areas/sections of the patient population.
- The scope of each ACO is likely to vary; some may include mental health services, others may include a subset of acute services. We have designed the Contract so that (as with the generic NHS Standard Contract) some provisions specific to particular types of service are able to be 'switched off' (i.e. omitted and replaced with "Not applicable") if those services are not within scope of a particular ACO. Equally, as we consider further the implications of including social care or public health services within local ACOs, we may need to clarify that certain provisions within the Contract (related to clinical healthcare or NHS-specific guidance) are not intended to apply to those services. We will work on this further as the Contract develops.

The service specification, outcome measures, and implications for contract management and assurance

7 The Contract contains a number of descriptors and indicators to define the requirements against which the Provider will be held to account. It contains a high level description of the mandatory core care model requirements, which will be supplemented locally by Commissioners through service specifications. The Provider will be required to report against the national outcome and process indicators contained in the incentives framework (in addition to complying with the generic nationally-mandated reporting requirements common to all NHS Standard Contracts), complemented by any indicators the CCG wishes to specify locally. An element of the Provider's total potential remuneration will be linked, via the Improvement Payment Scheme, to its achievement against locally-determined thresholds on both a locally-determined subset and a nationally-mandated subset of the indicators contained in the incentives framework.

8 The contract allows for the inclusion of these descriptions and indicators as follows:

a) The Service Conditions (particularly SC1.8 to SC4) contain the mandatory core elements of the care model.

b) Schedule 2C in the Particulars will contain the locally-determined service specifications, adding flesh to the nationally-mandated core requirements. These may comprise either solely the Commissioners' Service Requirements, or Commissioners' Service Requirements supplemented by the Provider's Service Proposals (setting out how it intends to meet the Commissioners' requirements).

c) Via GC9 (Information Requirements) and Schedule 7A (Reporting Requirements) the Provider will be required to report its performance against (amongst other things) the operational standards, national quality requirements, the full set of national indicators contained in the incentives framework, and any additional locally-determined indicators relevant to the local-determined Local Quality and Outcome Requirements.

d) Schedules 5A and B in the Particulars will set out minimum standards of performance required against nationally-mandated Operational Standards and National Quality Requirements. Schedule 5C will set out locally-determined Local Quality and Outcome Requirements (locally-determined thresholds (i) on a nationally-mandated subset and (ii) on a locally-determined subset of the indicators contained in the incentives framework, and (iii) on any additional locally-determined requirements). Failure to achieve any of these minimum standards or requirements may result in financial sanctions.

e) The specific indicators and thresholds (derived from the incentives framework) which must be achieved in order to unlock additional payment under the Improvement Payment Scheme, and the mechanism through which that payment will be determined and paid) will be set out in Schedule 5D.

9 The balance of these in existing commissioning arrangements differs by area and setting. Alone, none of them would sufficiently capture the requirements of an ACO and provide assurance of delivery. The way in which the three are balanced to do so will need to be considered by commissioners and evaluated by the Integrated Support and Assurance Process (ISAP). ISAP seeks to ensure value for public money, sufficient specificity in the local contract about what the ACO is to provide and what controls are in place regarding any potential change to services.

The Care Model

10 For an ACO (MCP or PACS) to be recognisable, the Contract must capture the essence of the care model, as expressed in the MCP and PACS frameworks. The requirements of the care model are described in the Service Conditions – particularly in Service Condition 3 and 4, for instance. All ACO contracts must include these requirements. The Service Conditions list requirements for how the set of services will need to be delivered, for example by requiring population health management, the use of information systems supported by risk stratification tools, or recording levels of patient activation.

11 It ensures that providers are fully aware of the commissioner's minimum expectations of delivery for an ACO. But the wording of the Service Conditions deliberately operates at a high level and does not describe the model of care in such a degree of depth as to prevent its evolution through learning or render it obsolete over the contract term.

Service specifications and clinical outcomes

12 Currently, commissioners often choose to develop service specifications which set out the details of individual services which providers are required to deliver and are prescriptive as to how those services are to be delivered. In an ACO context, longer term contracts require flexibility for ongoing service redesign. Pinning down the detail of services and how they are delivered too far would be overly restrictive. At the same time, some security about the nature of what the ACO must provide and what clinical and patient-reported outcomes it must achieve will be essential in holding the ACO to account for delivering high quality care. This might involve specifying types of services rather than their detail – or different approaches depending on the availability of good outcome measures. The key is to achieve the right balance.

13 The Contract will also need to be clear what process and obligations exist for the redesign of care, how commissioners are involved in the decision making, and how the Contract will evolve as services need to (subject always to the legal restrictions imposed by the Public Contract Regulations and the Procurement, Patient Choice and Competition Regulations and to commissioners' duties to consult their populations on proposed service reconfigurations).

14 The Contract leaves it to commissioners to decide how detailed they make their service specifications and to what extent they rely on specifying their required clinical and patient-reported outcomes to supplement the description of the care model and population outcomes. The Contract allows, at Schedule 2C, for a high-level description of the commissioners' service requirements to be augmented by a (more

detailed) set of service delivery proposals from the provider, developed during the procurement process – or, alternatively, there can be a single service specification which draws on both the commissioners' requirements as stated in procurement documents and the providers' proposals put forward during the procurement process.

15 However, the commissioner will need to ensure that it mitigates appropriately against any risk that, in order to improve its financial performance, the ACO restricts access to services or allows the quality or safety of care provision to deteriorate.

Population outcomes and the incentives framework for ACOs

16 The incentives framework for ACOs is the incentive scheme being created for ACO providers (including contracted-for PACS). We primarily describe here how it will apply to MCPs. The incentives framework for ACOs is a cornerstone of the Contract and will provide a view of:

- the overall performance of the ACO itself
- the contribution that the ACO is making to the wider health economy

17 The framework will provide commissioners with a view of the overall performance of the ACO and the contribution that the ACO is making to the wider health economy. It will provide commissioners, and the populations on whose behalf they commission care, with an overview of the performance and impact of the ACO. The information should be made accessible to the public, in order to provide transparency to the population served.

18 The threefold purpose of the framework is to:

a) provide a consistent data set for ACO benchmarking purposes and evaluation of impact, enabling best practice to be identified, shared and adopted;

b) as it evolves to assist in improving the quality of out-of-hospital data sets in the long-term; and

c) use payment to incentivise performance improvement across a small number of priority areas.

19 The framework includes the four following categories of indicators. Improvements in care quality, sustainability and health & wellbeing are each interdependent and will reinforce continued improvement between categories:

- **Health and Wellbeing Outcomes**: Indicators linked to population health outcomes and lifestyle factors;
- **Care Quality and Experience**: Indicators linked to positive patient experience, safe and effective care;
- **Sustainability**: Indicators focusing on the impact of the ACO on sustainability of the provider and system performance (note that the incentives to improve sustainability are largely within the integrated budget and gain/loss mechanism; please see the Finance and Payment Approach for ACOs for more detail); and
- **Transformation drivers**: this category includes key measures of leadership with a shared vision and the delivery mechanism for the new care model, as the drivers of long-term improvements in the other outcome areas.

20 A local ACO contract is anticipated to last for up to 10 years. Over this time period we can expect that clinical best practice will change, new technologies will become available and the public's expectations will change. We are taking a tiered approach to the framework indicators. Tier 1 indicators will relate to long-term outcomes which remain static for the full contract length, for example Potential Years of Life Lost. They signal a shared set of objectives for the system. Tier 2 indicators will relate to medium-term outcomes and processes, which may change over the life of the contract to reflect current priorities, for example rates of physical activity amongst adults.

21 More detail on the incentives framework can be found in the incentives framework for ACOs document.

Variations to the Contract

22 We recognise that the Contract will need to have room for flexibility in order to ensure that it continues to reflect the latest best practice and policy across the NHS. We have mirrored existing provisions within the generic NHS Standard Contract (the National Variation provisions) which allow NHS England to update the core terms of the Contract – for example where a new national priority is identified, or a contract provision needs to be updated.

23 In addition, of course, the Contract makes provision for variations (other than to the nationally mandated terms) to be agreed as necessary between commissioner and provider during the term of the contract (subject always to the legal restrictions imposed by the Public Contract Regulations).

Section-by-section descriptions

24 Set out below are high-level explanations of the function of each main section or schedule of the Contract, covering the Service Conditions, the General Conditions and the Particulars.

25 The following points should be noted:

- Details described below which deal with primary medical care services generally relate to provisions included in the Contract for the fully-integrated model, not for the partially-integrated model. That said, the majority of these provisions would apply for a partially-integrated model where the ACO is to be responsible for GP out-of-hours services;
- To accommodate those situations where a subset of acute hospital or mental health in-patient, outpatient and/or day case services is to be included within scope of an ACO, we have now amended the Contract to include those nationally-mandated provisions from the generic NHS Standard Contract which apply specifically to those services: SC26.5 in relation to VTE, and SC26.11 in relation to food standards, for example;

- We have also amended the Contract to allow for 'tailoring' of the Service Conditions and Particulars, in the same way as is possible with the generic NHS Standard Contract. Thus, if mental health or acute services are not included within scope of an ACO, for instance, the Contract provisions specific only to those services do not apply; and
- Detailed drafting notes in the Contract indicate how particular provisions are to be understood and how particular schedules are to be used, as well as highlighting in some instances areas where existing drafting may need to be further strengthened.

Service Conditions

26 The overall purpose of the Service Conditions is to set out the core requirements in clinical and service terms which any ACO will be required to deliver.

SC1 Fundamental Obligations of the Provider and the Commissioners

27 This provision sets out overall obligations on the parties at a very high level, including requirements to comply with fundamental care standards and the NHS Constitution. Also included (for the partially-integrated model) is a requirement to perform the Integration Functions set out in Schedule 3A.

(Source – expanded from the NHS Standard Contract)

SC2 The Population and the list of Registered Service Users

28 This provision, taken with the detail set out in Schedules 2A and 2B of the Particulars, defines the population and geographical area to be served by the ACO and describes the circumstances under which the ACO must and may provide primary medical and other care to individuals.

(Source – new addition for the ACO Contract)

SC3 Improving the Health of the Population

29 This provision sets out key responsibilities of the ACO for assessing population needs, addressing inequalities in health, wellbeing or outcomes, maximise disease prevention and ensure timely diagnosis and prompt access to clinically appropriate treatment and care. The provision also requires the ACO to have in place information systems and data sharing arrangements which allow risk stratification and targeting of care interventions.

(Source – new addition for the ACO Contract)

SC4 Care Tailored to Individual Needs

30 This provision sets out requirements on the ACO in terms of

- ensuring that patients have a choice of readily-accessible locations at which to receive primary medical care services during normal working hours and that its other services are sufficiently accessible to patients;
- organising care in an efficient manner and communicating appropriately with patients and carers, particularly in relation to the development of personalised care plans;
- agreeing and implementing plans for the roll-out and operation of personal budgets (covering health care and, where appropriate, social care) to people with long-term conditions; and
- ensuring that, where the legal right of choice of provider applies, people are offered this choice.

(Source – new addition for the ACO Contract, including elements adapted from the NHS Standard Contract and from draft Directions relating to ACO Contracts.)

SC5 Regulatory Requirements

31 This provision requires the ACO to comply with the requirements of regulatory or supervisory bodies (such as NHS Improvement or the Care Quality Commission), to respond to the recommendations arising from any audit or incident report and to have regard to (or comply with where mandatory) guidance issued by NICE.

(Source – NHS Standard Contract)

SC6 Service Standards

32 This requires the ACO to meet the national and local quality and outcome standards set out in the relevant Schedules (Schedule 5 A, B and C). (The national standards referred to include those in the NHS Constitution relating to access and waiting times.)

(Source – amended from the NHS Standard Contract)

SC7 Clinical and Service Governance

33 This requires the ACO to put in place an effective system of clinical governance and to ensure that it continuously reviews and evaluates the services it provides and makes ongoing improvements to services, reflecting the lessons learned from feedback, complaints, serious incidents, and surveys.

(Source – hybrid from draft Directions relating to ACO Contracts and the NHS Standard Contract)

SC8 Commissioner Requested Services / Essential Services

34 The Commissioner Requested Services (CRS) regime, overseen by NHS Improvement, is aimed at ensuring the continuity of services which have been designated as essential by commissioners in the event of the provider of such services facing serious financial difficulty. The Contract wording simply requires the ACO to comply with its obligations under this regime.

35 The CRS arrangements apply to Foundation Trusts and non-NHS providers, but not to NHS Trusts. For a situation where the ACO is an NHS Trust, therefore the Contract sets out alternative provisions which allow a subset of essential services to be identified and a continuity plan to ensure their continued availability to be recorded (at Schedule 2G and 2H respectively).

(Source – shortened from the NHS Standard Contract)

SC9 Staff

36 These provisions require the ACO to ensure that:

- its services have sufficient appropriately qualified and experienced clinical and non-clinical staff;
- staffing levels are planned and monitored and that the impact of staffing on service quality and outcomes is continuously reviewed;
- staff have appropriate access to induction, professional development, training and appraisal;
- proper pre-employment checks are carried out; and
- there are effective procedures in place through which staff can raise concerns about the safety and quality of services, with the ACO having a Freedom To Speak Up Guardian in place.

37 The provisions also require the ACO to put in place and implement a staff transition and development programme (Schedule 9A) – that is, a plan covering (as necessary) the training, development, physical relocation and reorganisation of staff over time to meet the requirements of the new care model.

(Source – hybrid from draft Directions relating to ACO Contracts and (chiefly) amended NHS Standard Contract)

SC10 Co-operation

38 The provision places broad requirements on the ACO and the commissioners to co-operate with each other to ensure that standards of care provided are consistently high, that care is well co-ordinated across different pathways and providers, with good continuity of care for patients, and that value for public money is maximised.

(Source – NHS Standard Contract)

SC11 Referral and Booking

39 These provisions deal with how the ACO is to receive and accept referrals and allow appointments to be booked into its services. ('Referral', as defined in the Contract, is essentially about a patient's first contact with the ACO for a particular condition or care pathway; this can include a self-referral or emergency presentation).

40 The provisions require that the ACO must accept clinically appropriate referrals into its services, in accordance with any referral protocols or clinical thresholds which may be set out in the contract locally (for instance in the Service Specifications at Schedule 2C or within Other Local Agreements, Policies and Procedures at Schedule 2J).

41 The provisions require that, in some instances, the ACO must also accept referrals into its services for patients whose Responsible Commissioner is not a party to this particular ACO Contract (in other words, patients from more distant CCGs). This provision applies where acceptance of a referral is necessary to give effect to a patient's legal right of choice of provider or in response to an emergency referral or presentation – so this provision would be relevant where, for example, mental health services are within the scope of the ACO.

42 The provisions then further require that:

- the ACO offers patients an online booking facility for appointments in primary medical care services, with sufficient appointment slots available;
- (under the partially-integrated model only) the ACO makes its services available to receive bookings from GPs and other primary care referrers through the NHS e-Referral Service, and uses reasonable endeavours to ensure that integrated GPs make referrals through that service; and
- where the ACO wishes to make an onward elective referral to a different provider, this is done wherever possible through the NHS eReferral Service.

(Source – hybrid from draft Directions relating to ACO Contracts and amended NHS Standard Contract)

SC12 Withholding and/or Discontinuation of Service

43 These provisions make clear that the ACO must not withhold a service from, or stop providing a service to a patient where to do so would be contrary to law or good clinical practice. But where (in cases of abusive, violent or threatening behaviour or other risk to staff) the ACO is forced to withhold a service temporarily, the Contract wording requires the ACO to make appropriate arrangements to resume delivery of services to such individuals promptly.

(Source – shortened and amended from the NHS Standard Contract)

SC13 Unmet Needs

44 This provision requires the ACO to notify the commissioner if it identifies an unmet need for health and social care (in respect of an individual patient or a group of patients) – that is, a need which is beyond the scope of the services which the ACO itself is commissioned to provide and also beyond the scope of other services which the commissioner has commissioned and which the ACO could refer into. It is then the commissioner's responsibility to determine any further action.

45 For the partially-integrated ACO model only, further provisions in this section set out arrangements for onward referral of patients, requiring the ACO to seek the agreement of the patient's GP before referring on a patient for non-immediate or routine treatment or care that is not directly related to the condition which was the subject of the patient's original referral.

(Source – amended from the NHS Standard Contract)

SC14 Public Involvement and Surveys

46 These provisions require the ACO to:

- involve and engage local people, its staff, primary care referrers and local community and voluntary sector organisations, particularly in considering and implementing developments to and redesign of services;
- provide all assistance reasonably required by commissioners in relation to the latter's statutory duties to carry out formal consultation on proposals for service reconfiguration;
- to operate the Friends and Family Test, seeking to maximise patient responses; and
- to carry out appropriate staff surveys and any other surveys (as set out in Schedule 7E).

(Source – hybrid from draft Directions relating to ACO Contracts and amended NHS Standard Contract)

SC15 Transfer of and Discharge from Care

47 These provisions set out requirements on the ACO when it is discharging patients from its care or transferring them to another provider. Under the provisions, the ACO must:

- have regard to relevant national guidance on discharge arrangements;
- use its best efforts to support safe, prompt discharge from hospital and to avoid emergency readmissions; and
- where transferring a patient to another provider, agree and implement a patient-specific care transfer plan.

48 For the partially-integrated model, additional conditions apply, covering the requirement for the provision of a discharge summary or clinic letter to the GP and for supply of medication on discharge from inpatient care or following clinic attendance. (These are not necessary in the fully-integrated model, because the primary and community services are then within the same provider organisation).

(Source – amended from the NHS Standard Contract)

SC16 Service User Health Records

49 These provisions require the ACO to maintain patient health records on electronic systems which enable ACO staff to record and view clinical information about patient care.

50 This section also requires that, from January 2019 (as under the NHS Standard Contract), the ACO's clinical IT systems must have the necessary open interoperable interfaces to allow key clinical data to be shared appropriately with healthcare professionals in other providers.

51 This section also sets out specific requirements for the ACO to:

- upload appropriate clinical information to, and enable relevant staff to view, each patient's Summary Care Record;
- ensure consistent use of the NHS Number;
- enter into a data-sharing agreement with other providers of urgent and emergency care services; and
- comply with existing requirements relating to the electronic transfer of patients' primary medical care records.

52 Finally, this section requires the ACO to put in place and implement an IT Development Programme (recorded at Schedule 10B), setting out its intentions for the developing, over time, the capability of its clinical and business intelligence systems.

(Source – hybrid from draft Directions and amended NHS Standard Contract)

SC17 Equity of Access, Equality and Non-Discrimination

53 These provisions require the ACO to avoid discrimination and to comply with the obligations set out in the Equality Act 2010. The ACO must also make reasonable adjustments for patients who do not speak English well or who have communication difficulties and implement the national workforce equality standards for race and disability.

(Source – NHS Standard Contract)

SC18 Other Local Agreements, Policies and Procedures

54 The Contract allows the parties to record other local agreements, policies and procedures at Schedule 2J. These could, for instance, be referral protocols or clinical thresholds for treatment or anything else which the parties will find it helpful to record within the local contract. The effect of the wording of Service Condition 18 is simply to give such agreements contractual force, meaning that each party must comply with any obligations set out in such documents.

(Source – NHS Standard Contract)

SC19 Service Development and Improvement Plan

55 A Service Development and Improvement Plan (SDIP) is a written plan, agreed between the commissioner and the ACO, setting actions to be taken to improve any aspect of the services. Once agreed, an SDIP is included within the local contract at Schedule 7D. SDIPs may be agreed at any time to address local priorities, but NHS England may also from time to time mandate the agreement of SDIPs to cover specific policy priorities. The effect of the wording of Service Condition 19 is simply to give SDIPs contractual force, meaning that each party must comply with any obligations set out in an SDIP.

(Source – NHS Standard Contract)

SC20 Services Environment and Equipment

56 These provisions require the ACO to make sure that the premises in which services are provided and the equipment used are fit for purpose and that staff receive appropriate training in the use of equipment.

57 They also require the ACO to put in place an implement a Services Environment Development Plan (recorded at Schedule 10A), setting out its plans for the utilisation and development of its estate.

(Source – amended from the NHS Standard Contract)

SC21 Duty of Candour

58 These provisions require the ACO to comply with statutory 'duty of candour' requirements to be open and transparent with patients and their families about any problems or incidents which arise with their care.

(Source – NHS Standard Contract)

SC22 Complaints and Investigations

59 This section requires both the commissioners and the ACO to publish and operate appropriate complaints procedures. There are further requirements on the ACO in relation to the way in which complaints procedures must be publicised to patients and their families.

(Source – hybrid from draft Directions relating to ACO Contracts and amended NHS Standard Contract)

SC23 Incidents Requiring Reporting

60 This section requires the ACO to comply with the NHS Serious Incident Framework and the Never Event Policy Framework.

(Source – hybrid from draft Directions relating to ACO Contracts and amended NHS Standard Contract)

SC24 Safeguarding, Mental Capacity and Prevent

61 These provisions set out requirements on the ACO in relation to its policies and procedures on adult and child safeguarding and its arrangements for meeting its obligations under the Mental Capacity Act, including requirements for staff training in both areas. This section also requires the ACO to comply with national guidance on implementation of the Government's Prevent (anti-radicalisation) strategy.

(Source – NHS Standard Contract)

SC25 Emergency Preparedness, Resilience and Response

62 This section requires the ACO to comply with national guidance on emergency preparedness, to put in place both an Incident Response Plan and a Business Continuity Plan and to provide appropriate support and assistance to the commissioners in the event of a public health emergency or incident. In respect of acute services, this section sets out particular requirements (as per the generic NHS Standard Contract, recognising the specific role of acute service providers in responding to emergencies and incidents.

(Source – NHS Standard Contract)

SC26 Other National Policy Requirements

63 This section sets out brief requirements on the ACO relating to the identification and operation of places of safety for patients with mental health problems; arrangements for infection control; arrangements for pastoral and spiritual care; arrangements for sustainable development, including action on carbon reduction; food standards (for patients, visitors and staff); involvement in and support of clinical networks, national audit programmes and approved research studies; and the care of dying people.

(Source – NHS Standard Contract)

SC27 Death of a Service User

64 These provisions set out a requirement for the ACO to report the death of any patient to the commissioner, with additional detail to be provided in respect of any patient who dies on the ACO's own premises.

(Source – hybrid from draft Directions relating to ACO Contracts and the NHS Standard Contract)

SC28 Certificates and Provision of Information to a Relevant Person

65 These provisions require the ACO to issue relevant medical certificates to patients.

(Source – draft Directions relating to ACO Contracts)

SC29 Prescribing

66 Under these provisions, the ACO must:

- comply with a number of specific requirements in relation to the prescribing of medication; and
- publish its formulary and ensure that it makes available to patients all relevant treatments recommended in positive NICE Technology Appraisals.

(Source – hybrid from draft Directions relating to ACO Contracts and NHS Standard Contract)

SC30 Further Miscellaneous Requirements in relation to Primary Medical Services

67 These miscellaneous provisions apply only to primary medical care services and set out, for instance, arrangements for telephone services, including ensuring patients are not charged a premium rate for calls.

(Source – draft Directions relating toACO Contracts)

General Conditions

68 The overall purpose of the General Conditions is to set out necessary contract management processes and generic legal requirements. The General Conditions also contain a full list of the defined terms used in the Contract.

GC1 Definitions and Interpretation

69 Throughout, the Contract uses a range of capitalised 'defined terms'. For each defined term there is a definition set out in the Definitions and Interpretation section of the Contract (at the end of the General Conditions). This provision simply states that the Contract must be interpreted in accordance with these detailed definitions. It also sets out the order of precedence of the different sections of the Contract in case of conflict or inconsistency between them.

(Source – NHS Standard Contract)

GC2-4 Effective Date and Duration, Service Commencement, Transition Period

70 These provisions:

- set out the date on which the Contract becomes effective and the date on which it expires (the actual dates themselves are recorded in the opening section of the Particulars);
- require the ACO to satisfy any Conditions Precedent (set out in Schedule 1A) and to commence delivery of the services on the later of the Expected Service Commencement Date (set out in the opening section of the Particulars) or the day after the date on which all the Conditions Precedent are satisfied; and

- require the parties to implement any specific Transition Arrangements (in relation to mobilisation of the services under the new contract) which have been agreed and recorded at Schedule 2K.

(Source – NHS Standard Contract)

GC5 CCG Membership

71 This provision, which only applies under the fully-integrated model, requires that the ACO must be a member of each CCG which is a party to the contract.

(Source – new addition specifically for the ACO Contract, but consistent with GP contracts)

GC6 Co-ordinating Commissioner and Representatives

72 This provision identifies that (where there is more than one commissioner organisation which is party to the contract) one of those commissioners will act as Co-ordinating Commissioner acting as agent of the all the commissioners in undertaking a variety of contract management roles. Each individual commissioner remains a separate party to the contract and separately responsible for its own actions and financial liabilities. The provision also requires that each commissioner and the ACO will also nominate a representative to act as their key contact for day-to-day contract management. (The names of the Co-ordinating Commissioner and the Commissioner and Provider Representatives are set out in the opening section of the Particulars).

(Source – NHS Standard Contract)

GC7 Review

73 This provision allows for the Co-ordinating Commissioner and the ACO to hold meetings to review and discuss any matters in relation to the Contract. The standard frequency of Review Meetings is set out separately in the opening section of the Particulars. Urgent review meetings can also be called by either party on five days' notice.

(Source - NHS Standard Contract)

GC8 Contract Management

74 These provisions set out the processes by which the performance by each party of its obligations under the contract can be managed. The separate steps involved are, in short:

- issuing a Contract Performance Notice (indicating that one party believes the other to have breached a contractual obligation);
- holding a Contract Management Meeting to discuss the Contract Performance Notice;
- where necessary, undertaking a Joint Investigation to establish whether a contractual requirement has been breached; and
- agreeing and implementing a Remedial Action Plan (RAP) to put right any breach that has occurred.

75 By agreement, a RAP may set out financial consequences (for either commissioner or ACO) which apply where there is a subsequent breach of the agreed RAP.

76 The Contract provisions set out further circumstances in which, having gone through the contract management process, the Co-ordinating Commissioner may withhold funding from the ACO. This is the case where either:

- the parties have not been able to agree a RAP due to any unreasonable behaviour by the ACO; or
- a RAP has been agreed without specific financial consequences; the ACO breaches this and fails to remedy the breach even after the Co-ordinating Commissioner has issued an Exception Report to the ACO board detailing this failure.

77 In these situations, the Contract provisions allow the Co-ordinating Commissioner to withhold from the ACO reasonable and proportionate sums up to a specified maximum level. Initially, such withholding is temporary, with the sums repaid once the breach has been remedied. However, where the ACO remains in breach of a RAP four weeks after the Co-ordinating Commissioner has issued an Exception Report, the sums withheld may be retained permanently.

(Source – NHS Standard Contract)

GC9 Information Requirements

78 These provisions

- require the ACO to comply with NHS information standards and to submit data and provide information and reports to national bodies and to commissioners locally (in line with the detailed requirements set out in Schedule 7A)
- introduce the concept of an Information Breach (broadly, a failure by the ACO to comply with the requirements of General Condition 9 and Schedule 7A) and allow the Co-ordinating Commissioner to withhold or retain reasonable and proportionate sums in respect of Information Breaches
- enable the parties to agree, at any time, a Data Quality Improvement Plan (to be included at Schedule 7B).

(Source – shortened from the NHS Standard Contract)

GC10 Monitoring Activity

79 In comparison to traditional contracting models, the ACO Contract focusses less on monitoring volumes of patient activity. The provisions in this area are therefore very light-touch, but they allow the parties, if they wish, to agree an Indicative Activity Plan (setting out, at Schedule 2E, the expected number and case mix of patients to be treated by the ACO's different services each year) and Activity Planning Assumptions (setting out, at Schedule 2F, the underlying factors which will influence the level of activity, such as referral volumes) – and to monitor actual activity against plan.

(Source – shortened and amended from the NHS Standard Contract)

GC11 Payment Terms

80 These provisions set out the arrangements under which the ACO will be paid by the commissioners. The provisions:

- describe the Whole Population Annual Payment (set out in Schedule 4A) and how it is to be adjusted over time (set out in Schedule 4B);
- set out the process and timescales for up-front monthly payments on account to be made by the commissioners, with a subsequent monthly process for reconciliation and validation of the final level of payment;
- set out (provisional) arrangements for payment in respect of activity-based and other payment streams which are outwith the WPAP;
- set out a process for dealing with contested payments and require additional interest to be paid on late payments;
- require commissioners to apply any financial sanctions set out in Schedules 5A, B, C and E in respect of breaches of national and local quality and outcome standards (except in specific situations where the ACO is receiving funding from the national Sustainability and Transformation Fund); and
- require the ACO to administer and collect all statutory charges which patients are liable to pay, including under the overseas visitor charging regulations.

(Source – hybrid from APMS Directions and shortened / amended NHS Standard Contract, plus new content specific for the ACO Contract)

GC12 Improvement Payment Scheme

81 These provisions set out the process through which the ACO can earn payment under an Improvement Payment Scheme (to replace CQUIN and, for the fully-integrated model, QOF). National guidance on this Scheme will be set out separately.

82 The detailed arrangements allow for the detail of the Scheme to be set out at Schedule 5D, including the level of any payments to be made in advance. They require the ACO to submit reports to the Co-ordinating Commissioner, showing its progress against the Scheme and set out a process whereby the final level of payment due under the Scheme can be determined and made.

(Source – new addition for the ACO Contract, but closely based on current mechanics for CQUIN schemes)

GC13 Gain/Loss Share Arrangement

83 The Contract enables the parties to agree a gain-and-loss-share arrangement in relation to the commissioners' level of expenditure on acute hospital services. The details of the operation of this arrangement, to be agreed locally in line with national guidance, would be set out in Schedule 4C. General Condition 13 simply requires the parties to operate the arrangement described in the Schedule.

(Source – new addition for the ACO Contract)

GC14 Liability and Indemnity

84 These provisions:

- require the ACO to indemnify the commissioners against losses (broadly defined) which the commissioners may suffer as a result of the ACO's negligence or breach of contract and vice versa;
- require the ACO to put in place (and to ensure that any sub-contractors it employs also put in place) appropriate indemnity arrangements in respect of employers' and public liability and clinical and professional negligence. This means that it is the ACO's responsibility to ensure all employees have clinical negligence cover, and to pay for this cover or reimburse employees where they have secured the cover themselves; and
- require the ACO to ensure (and demonstrate to the Co-ordinating Commissioner) that the indemnity arrangements it has put in place in respect of clinical negligence will cover a period of 21 years following termination or expiry of the contract.

(Source – NHS Standard Contract)

GC15 Assignment and Sub-Contracting

85 These provisions set out obligations on the ACO and the commissioners as to the extent to which they may transfer, assign or sub-contract to other bodies their rights and obligations under the contract.

86 The ACO may not assign or novate the Contract without the approval of the Co-ordinating Commissioner, who may require any replacement ACO to provide a guarantee from its parent or another party as a condition of giving that approval.

87 In respect of sub-contracting by the ACO, the provisions:

- require that the decision by the ACO to let a sub-contract is subject to the approval of the Co-ordinating Commissioner and (where relating to primary medical services) NHS England;
- impose further restrictions on sub-contracting of primary medical services, consistent with current PMS requirements (including those relating to sale of goodwill);
- state that such approval may also cover the terms and form of the proposed sub-contract;
- set out that, as a condition of approval, the sub-contractor may be required to sign a Direct Agreement with the commissioners (under which – in the event of financial failure of the ACO organisation – the commissioners can automatically become the direct commissioners of the sub-contracted services, thus protecting service continuity);
- allow the commissioners to require a sub-contractor to be appointed, removed or replaced in specific circumstances – for example, where existing arrangements are failing; and
- make clear that the ACO remains responsible to the commissioner for the performance of any sub-contractors it employs.

(Source – hybrid from draft Directions relating to ACO/ Contracts) and amended NHS Standard Contract)

GC16 Variations

88 This section deals with how the local provisions of the contract may be varied during its term. The key points are these.

- The Contract distinguishes between those elements which may be varied by the parties locally (the bulk of the content of the Particulars) and those which may not (the General and Service Conditions).
- NHS England may at any time publish a National Variation to the national terms of the Contract; failure by the ACO to accept a National Variation may lead to termination of the local contract.
- The parties may record, at the commencement of the contract, a series of Scheduled Variations (at Schedule 8) which the Co-ordinating Commissioner may then enact at its discretion. These are pre-planned changes to the scope and scale of the contract – such as the intention, for example to bring additional services into the ACO's scope at a particular point in the future. It is essential, under the Public Contract Regulations 2015, that as far as possible such planned future changes are set out clearly in the Prior Information Notice or Contract Notice published by the commissioner at the outset of its procurement process and in the contract itself.
- Otherwise, General Condition 16 sets out a process by which either party can propose, and the parties can together agree and implement, variations to any of those elements of the contract for which local variation is permitted. The wording makes clear that such variations must be agreed by all parties; they cannot be imposed.
- However, the Co-ordinating Commissioner may require a variation to the Commissioners' Service Requirements or the Provider's Service Proposals where that is necessary to deal with inconsistencies between them or with poor performance.

(Source – expanded from NHS Standard Contract)

GC17 Dispute Resolution

89 These provisions set out a process for the resolution of any disputes which may arise once the contract has been signed. The process involves three stages:

- escalated negotiation, involving senior staff within each party not previously involved in discussions about the disputed issue;
- mediation, organised by NHS England and NHS Improvement where the ACO is an NHS Trust and by the Centre for Effective Dispute Resolution (CEDR) (or an equivalent independent body) in all other cases; and
- expert determination, under which an expert in the relevant field, identified and agreed locally between the parties or nominated by CEDR, reviews submissions from the parties in relation to the disputed issue and gives a final and binding judgement on the appropriate outcome.

(Source – NHS Standard Contract)

GC18 Financial Transparency and Audit; Transparency of Earnings

90 These provisions:

- require the ACO to produce an audited Financial Business Plan at the start of the Contract, to be updated and audited annually to demonstrate that it remains accurate and based on reasonable and prudent assumptions. This plan will provide the benchmark for consideration of variations to service requirements and adjustments to the WPAP;
- oblige the ACO to operate an open-book accounting process vis-à-vis the commissioner, providing periodic audited financial statements of actual income and expenditure; and
- require the ACO and any sub-contractors to publish annual
  - average annual GP earnings (as required under current primary care contracts);
  - actual annual remuneration of directors (or equivalent) and the ratio of median annual staff remuneration to annual remuneration of the highest-paid director, (in line with the requirements on NHS providers under Department of Health accounting rules); and
  - earnings of any employee earning above £142,500.

(Source – new addition for the ACO Contract, in part reflecting draft Directions relating to ACO Contracts)

GC19 Undertakings in Relation to Financial Matters and Assets

91 This section includes provisions which:

- require the ACO to maintain an agreed level of Minimum Net Worth (broadly calculated as its assets minus its liabilities) and an agreed ratio of current liabilities to current assets;
- require the ACO to maintain a register of its assets and place certain restrictions on the control and disposal of such assets;
- require the ACO to devote itself to exclusively to the business contemplated by the Contract;
- place restrictions the ability of the ACO to offer credit or loans and to take on debt; and
- require the ACO to pay all taxes due in a timely manner, avoiding fines for late payment.

(Source – new addition for the ACO Contract)

GC20 Provider Distributions and Dealings With Shares or Membership Interests

92 These provisions set out that the ACO is only able to distribute profit (or equivalent) to shareholders and others when particular conditions are met. The conditions are intended to ensure, for instance, that profit in relation to a particular period is only distributed a) when the ACO has met the required service standards and outcomes during that period and b) that sufficient funds are available within the ACO for profit to be distributed without any adverse impact on the ability of the ACO to deliver its contractual obligations.

(Source – new addition for the ACO Contract)

GC21 Inspection and Quality Audit

93 These provisions:

- set out arrangements under which national regulatory and supervisory bodies, commissioners and their representatives can enter the ACO's premises for the purpose of observing, auditing or inspecting the premises and the services being provided;
- require the ACO to implement and/or respond to relevant recommendations made in any report by a national regulatory or supervisory body or as a result of any audit;
- require the ACO to implement an ongoing programme of clinical audit and report on this to the Co-ordinating Commissioner; and
- allow the Co-ordinating Commissioner to appoint an auditor to audit any aspect of the ACO's performance under the contract, including the clinical services provided and the charges made for these.

(Source – hybrid from draft Directions relating to ACO Contracts and shortened NHS Standard Contract)

GC22 Suspension

94 Under these provisions, the Co-ordinating Commissioner is able – in specific, defined circumstances – to require the ACO to suspend provision of a particular service (for instance, where there are material concerns about the safety of the service). Provision of the service may then only be recommenced once the ACO can demonstrate that it can provide the service to the required standard. For the period for which the service is suspended, the commissioners may make an appropriate reduction in the amount they pay to the ACO.

As an alternative, or in addition, to suspending the relevant services, the Co-ordinating Commissioner may require the removal or replacement of a sub-contractor, the appointment of one or more new sub-contractors, the agreement of a remedial action plan, and/or to be represented at Provider board meetings at which the issues in question are to be discussed.

(Source – from the NHS Standard Contract, with additional content)

GC23-25 Termination, Consequence of Expiry or Termination, Provisions Surviving Termination

95 General Condition 23 sets out the circumstances in which the contract may be terminated by either party before its expiry date and the process to be followed for termination to be effected. The provisions allow for termination on a no-fault basis by either party, with a notice period determined locally and recorded in the Particulars. They also allow for termination with immediate effect in specific instances of default, either by the ACO or by the commissioners.

96 General Condition 24 deals with what happens when the contract expires or is terminated. The provisions place a requirement on the ACO to assist the commissioners in managing the transition to a new provider, ensuring continuity of service provision. They require both parties to implement any Exit Arrangements – which may include financial arrangements (agreed locally and recorded in Schedule 11).

97 General Condition 25 confirms that any rights, duties or obligations which are expressed to survive (or which by implication survive) the expiry or termination for any reason of the contract, together with all indemnities, will continue after expiry or termination, subject to any limitations of time expressed in the contract.

(Source – amended from the NHS Standard Contract)

GC26 Employment or Engagement following NHS Redundancy

98 These provisions relate to situations where the ACO intends to employ an individual who has recently received a redundancy settlement after being made redundant from a Very Senior Manager position with in an NHS organisation. The provisions effectively require the ACO to ensure that, if it does employ such an individual, arrangements are made for the repayment of the redundancy settlement, either in full or in part, based on a formula set out within the Contract wording.

(Source – NHS Standard Contract)

GC27 Confidential Information of the Parties

99 These provisions allow management information shared by one party with the other to be identified as confidential and then set out circumstances in which such information may and may not be disclosed by the party which receives it.

(Source – NHS Standard Contract)

GC28 Patient Confidentiality, Data Protection, Freedom of Information and Transparency

100 These provisions:

- set out detailed requirements on the ACO in relation to information governance and the protection of personal confidential data; and
- describe the responsibilities of the ACO to assist the commissioners in complying with its disclosure obligations under the Freedom of Information Act and the Environmental Information Regulations.

(Source – NHS Standard Contract)

GC29 Intellectual Property

101 These provisions set out the arrangements for managing the intellectual property rights (IPR) of either party. In essence the provisions state that no party will acquire the IPR of any other party but that each may use the other party's intellectual property – in the ACOs' case for the sole purpose of providing the services, in the commissioners' case for the exercise of any of their statutory functions.

(Source – NHS Standard Contract)

GC30 NHS Identity, Marketing and Promotion

102 These provisions require the ACO to comply with the NHS Identity Guidelines (including for instance use of the NHS logo).

(Source – NHS Standard Contract)

GC31 NHS Counter Fraud and Security Management

103 This section sets out requirements on the ACO for ensuring that it has adequate counter-fraud arrangements in place and cooperates appropriately with NHS Protect.

(Source – NHS Standard Contract)

GC32 NHS Accounting

104 We have included provisions here highlighting the need for the ACO to provide certain accounting information to DH if it is a body within the DH group for accounting purposes. We will be working with DH to refine these requirements over the coming months.

GC33 Change in Control

105 These provisions require prior agreement of the Co-ordinating Commissioner to a change in voting control of the provider entity which holds the ACO Contract, or of a Material Sub-Contractor (other than where that entity is a public company); consent is not generally required for other transfers of shares or membership interests in the ACO, but the provisions do require the ACO to notify the Co-ordinating Commissioner of them.

(Source – amended from the NHS Standard Contract)

GC34 – 47 Miscellaneous provisions

106 These legal 'boilerplate' provisions cover a number of different areas. For instance, they set out how conflicts of interest are to be managed; they define certain 'prohibited acts'; they set out the contractual position in cases of force majeure; they describe situations in which third parties may exercise rights under the Contract; and they define how formal notices under the Contract are to be served.

(Source – largely from the NHS Standard Contract)

Particulars

107 The Particulars contain all the sections which require local input, including details of the parties to the contract, the service specifications and schedules relating to payment, quality standards and reporting. The tables below describe, for each Schedule in the Particulars, the content which is expected to be included.

Schedule 1 – Service Commencement and Contract Term

A	Conditions Precedent	Insert here details of any documents that must be provided and/or actions which must be completed by the ACO before it can start providing services.
B	Commissioner Documents	Insert here details of any specific documents that have to be provided by the Commissioner(s) to the ACO prior to Service Commencement.
C	Extension of Contract Term	Record here any provision made locally (as part of an open procurement process) for the duration of the contract to be extended.
D	Key Documents	Include here supporting contracts and other arrangements which are not to be varied, terminated etc without the consent of the Co-ordinating Commissioner.

Schedule 2 – The services

A	The Population	Include here details of the population which the ACO services.
B	The Contract Area	Include here a locally-determined map outlining the geographic area which the ACO serves.
C	Service Specifications	
C1	Commissioners' Service Requirements	Include here local descriptions of the services to be provided by the ACO, to the level of detail seen as desirable by the commissioner. May cover inputs, volumes and/or clinical outcomes. Must make clear which services are in scope and out of scope and must define clearly the boundaries between the activities which are to remain the responsibility of the CCG, and those which are to be assumed by the ACO.
C2	Provider's Service Proposals	Include here how the provider intends to satisfy the commissioners' requirements at C1 above. These proposals should be developed and agreed through the course of the procurement process (and might be varied by agreement at different points during the term of the contract). As an alternative to separate Commissioners' Service Requirements and Provider's Service Proposals, Schedule 2C may instead set out Service Specifications which draw on both the Commissioners' requirements as stated in procurement documents and the Provider's proposals put forward during the procurement process.
C3	Excepted Services	List here those Services other than primary medical essential services which the parties have agreed that the provider will not be required to provide to members of the ACO Population who are not permanently or temporarily resident in the ACO Area.
D	Not used	
E	Indicative Activity Plan	Include here, if desired, locally-determined indicative volumes of activity expected to be undertaken by the ACO in different services (for purposes of monitoring, not payment).
F	Activity Planning Assumptions	Include here, if desired, locally-determined assumptions (about demographic change, disease prevalence, clinical need, referral and treatment rates) which will influence demand for the service the ACO provides.
G	Essential Services	List here Essential Services (identified by commissioners locally) (NHS Trusts only – CRS regime applies to other providers).
H	Essential Services Continuity Plan	Include here the ACO's Continuity Plan for Essential Services (NHS Trusts only – CRS regime applies to other providers).
I	Clinical Networks	Set out here any Clinical Networks in which the Provider is required to participate.

Schedule 2 – The services *continued*

J	Other Local Agreements, Policies and Procedures	If there are specific local agreements, policies and procedures with which the ACO and/or Commissioner(s) are to comply, enter details of them here.
K	Transition Arrangements	There may be certain things that need to be done before the Service Commencement Date in order that services commence smoothly. Details of any such arrangements should be inserted here.
L	Transfer of and Discharge from Care Protocols	Include here any local protocols which the ACO must comply with.
M	Safeguarding Policies and Mental Capacity Act Policies	Include here any local policies which the ACO must comply with.

Schedule 3 – Integration Activities (partially-integrated ACO only)

A	Integration Activities	Include here a locally-drafted description of how the ACO will work with local general practices to ensure that primary and community services are fully integrated. This should be consistent with the Integration Agreement signed by the ACO and general practices.
B	Integration Goals	Include here the underpinning goals which the ACO is intended to pursue in terms of integration of its services with general practice services.
C	Associate Practices	List here the GP practices with which the ACO is to integrate. It is the aggregate of these Associate Practices' patient lists that will largely define the patient population to be served by the ACO under the partially integrated model.
D	Integrated Providers	List here providers of other health and social care services with whom the ACO must integrate.

Schedule 4 – Payment

A	Whole Population Annual Payment	Describe here the opening Whole Population Annual Payment which the ACO will earn, allocated between different commissioners as appropriate.
B	Adjustment of Whole Population Annual Payment	Describe here agreed arrangements by which the WPAP will be periodically adjusted – for scheduled and unscheduled variations and for other factors.
C	Activity-Based Payments and Other Payment Streams	Describe here any activity-based payments – eg in relation to vaccination programmes – which will form potential (conditional) ACO income streams outside the WPAP.
D	Gain/Loss Share Arrangement	Describe here the gain-and-loss-share arrangement in relation to the commissioners' expenditure on acute hospital services.
E	Local Variations	Insert here the completed NHS Improvement template for each Local Variation to National Prices or Currencies reflected in the WPAP and any adjustment to it.
F	Development Plan for Integrated Personal Commissioning	Set out the practical arrangements for rolling-out the offer of personal budgets for healthcare and (where appropriate) social care to relevant patients, making clear whether this is to be done by the ACO from within the WPAP or by the CCG with the ACO's assistance.

Schedule 5 – Quality Requirements

A	Operational Standards	These are NHS Constitution and equivalent standards, to be included only where relevant to the services within scope of the ACO.
B	National Quality Requirements	These are other nationally-set quality standards, to be included only where relevant to the services within scope of the ACO.
C	Local Quality and Outcome Requirements	Include here locally-determined quality and outcome measures which the ACO must deliver - these may include process (input) measures, service-specific clinical outcomes or measures of patient experience.
D	Improvement Payment Scheme	Include here details of the national Scheme to replace CQUIN and, for the fully-integrated model, QOF.
E	Clostridium difficile	This sets out the arrangements for determining any financial sanction in relation to cases of clostridium difficile at an ACO which provides acute inpatient services.

Schedule 6 - Governance

A	Documents Relied On	Identify here any documents, consents or certificates that have been relied on by any party in deciding whether to enter the contract.
B1	Provider's Mandatory Material Sub-Contractors	Include here details of any sub-contractors which the ACO **must** use.
B2	Provider's Permitted Material Sub-Contractors	Include here details of any other sub-contractors which the ACO uses.
B3	Sub-Contract Direct Agreement	Include here the template Sub-Contractor Direct Agreement (to be entered into between the Commissioner(s), the ACO and the Sub-Contractor (model version to be provided nationally).

Schedule 7 - Contract Management, Reporting and Information Requirements

A	Reporting Requirements	This sets out nationally-mandated requirements for central submission of datasets, completion of the proposed ACO dashboard and local submission of contract reports by the ACO to the commissioner. Additional local requirements can be added as necessary.
B	Data Quality Improvement Plans (DQIP)	DQIPs can be added to the contract as and when agreed locally.
C	Incidents Requiring Reporting Procedure	Insert here the details of the agreed procedures for reporting, investigating, and implementing and sharing lessons learned from Serious Incidents, Reportable Patient Safety Incidents and Other Patient Safety Incidents.
D	Service Development and Improvement Plans (SDIPs)	SDIPs can be added to the contract as and when agreed locally.
E	Surveys	Insert here the requirements for frequency, reporting and publication of mandated surveys and any additional locally agreed surveys.
F	Provider Financial Business Plan	Include here details of the ACO's proposed financial business plan.
G	Data Requirements	Include here the information that each party requires from the other in order to perform their respective roles and obligations under the contract.
H	Data Processors	Insert here a list of the data processors to be used by the ACO, enabling the commissioners to maintain visibility of the processors involved in the delivery of the contract.
I	Provider Data Processing Agreement	Sets out the detailed arrangements under which the ACO will act as data processor on behalf of the commissioners.

Schedule 8 – Scheduled variations

A	Scheduled Variations	Describe here any planned variations which are known at the outset of the contract and which may be implemented at the commissioner's discretion at particular points – potentially covering new services being brought into ACO scope, for instance.

Schedule 9 - Staff

A	Staff Transition and Development Programme	Include here the ACO's plan for training, development, physical relocation and reorganisation of staff over time to meet the requirements of the new care model.
B	TUPE	This sections sets out nationally mandated requirements in relation to staff transfers under TUPE.
C	Pensions	Local provisions (based on published template provisions) will be included here.

Schedule 10 – Services Environment Development Programme and IT Development Programme

A	Services Environment Development Programme	Include here the ACO's programmes for developing its physical premises in order to be able to deliver the new care model.
B	IT Development Programme	Include here the ACO's programmes for developing its IT capabilities in order to deliver the new care model.

Schedule 11 – Exit Arrangements

A	Exit Arrangements	Include here details of practical and financial arrangements to take effect on expiry or termination of the contract.

Schedule 12 – Guarantee

A	Guarantee	Include here the Template Guarantee which may be required to be provided as a condition of consent to assignment or change in control (model version being drafted nationally).

Appendix 1

Draft Directions in relation to ACO contracts: how and where they are reflected in the ACO Contract

ACO contract provision	Draft Direction reflected or referred to in the ACO Contract	Corresponding provision in 2015 PMS Regulations	Requirement
Particulars - Services	Direction 5 (1) (d)	Regulation 22	Whether out of hours services are to be provided
Particulars – Contract Management	Direction 5 (1) (a)	Regulations 9 - 12	Status of the contract
Service Conditions (SC)			
SC 2	Schedule 3 paragraphs 7, 8, 12, 13	Schedule 2, paragraphs 13, 17,18 3	List of patients; Registering out of area patients; Inclusion in list of patients: armed services personnel and requirement relating to temporary residents
SC 4.2.1 and 4.16.4	Schedule 3 paragraph 14	Schedule 2, paragraph 21	Patient preference of practitioner
SC4.2, SC6.1.3	Direction 14 (1)	Regulation 22	Requirements applicable where the contractor is required to provide OOH services
SC 4.17	Schedule 3 paragraph 10	Schedule 2, paragraph 15	Accountable GP
SC 4.18	Schedule 3 paragraph 11	Schedule 2, paragraph 16	Patients aged 75 years and over: accountable GP
SC 4.19	Schedule 3 paragraph 9	Schedule 2, paragraph 14	Newly registered patients - alcohol dependency screening
SC 7.1	Direction 47	Regulation 79	Clinical governance
SC 9.5.1	Directions 16 - 19	Regulations 33 to 36	Qualification of performers
SC 9.6	Directions 20 - 23	Regulation 37, 38, 42, 43	Terms and conditions for employment and engagement
SC 9.10	Direction 50	Regulation 82	Co-operation with the Secretary of State and Health Education England
SC 10.6	Schedule 3 paragraph 6	Schedule 2, paragraph 10	Duty of co-operation with OOH providers
SC 11.5	Direction 40	Regulation 64	Patient online service

ACO contract provision	Draft Direction reflected or referred to in the ACO Contract	Corresponding provision in 2015 PMS Regulations	Requirement
SC 14.4	Direction 10	Regulation 20	Patient Participation - to allow patients to provide specific comments on primary medical services.
SC14.5	Direction 48	Regulation 80	Friends and Family Test
SC 16.1	Direction 36	Regulation 60	Patient records
SC 16.10	Direction 37	Regulation 61	Summary Care Record
SC 16.12	Direction 39	Regulation 63	Use of NHS number
SC 16.14	Direction 38	Regulation 62	Electronic transfer of patient records
SC 22	Directions 45, 46	Regulation 72, 73	Complaints procedure; co-operation with investigations
SC 26.2	Schedule 3 paragraph 5	Paragraph 9	Infection control
SC 27.2	Schedule 3 paragraph 15	Part 7, paragraph 47	Notice of deaths
SC 28	Direction 7	Regulation 15	Requirements relating to certificates in the provision of primary medical services
SC 28.2	Direction 7 and Schedule 1	Regulation 15 and Schedule 1	Provision of prescribed medical certificates
SC 28.4	Direction 42	Regulation 69	Provision of information to a medical officer
SC 29.1, 29.2	Directions 24 – 35, Schedule 3 paragraph 16	Regulations 48 – 59, 44	Terms for prescribing and dispensing; notice requirements for prescribers
SC 30.1 and 30.2	Schedule 3 paragraphs 1 and 2	Schedule 2 paragraphs 3 and 4	Telephone services - and cost of relevant calls
SC 30.3	Schedule 3 paragraph 3	Schedule 2 paragraph 7	Clinical reports
SC 30.4	Schedule 3 paragraph 4	Paragraph 8	Storage of vaccines
SC 30.5	Direction 44	Regulation 68	Inquiries about prescriptions and referrals
SC 30.6	Direction 49	Regulation 73	Co-operation with NHS England
SC 30.7	Direction 14 (2)	Regulation 22	Requirements applicable where the contractor is not required to provide OOH services

ACO contract provision	Draft Direction reflected or referred to in the ACO Contract	Corresponding provision in 2015 PMS Regulations	Requirement
General Conditions (GC)			
GC 5	Direction 6	Part 5, paragraph 14	Requires contractor to be a member of CCG; Appointment of an individual to act on contractor's behalf in dealings between the contractor and CCG
GC 9.2.2	Directions 41 and 43 Direction 14(2)	Regulations 67, 67A	Provision of information; GP access data; OOH data
GC 11.21 – 11.24	Direction 8 and Schedule 2	Regulations 18, 19	Fees and charges in relation to primary medical services; circumstances in which fees and charges may be made
GC 14.3	Directions 51, 52	Regulations 83, 84	Insurance; Public Liability insurance
GC 15	Direction 5 (1) (b) and (c)	Regulation 23 and Part 5 of Schedule 2	Circumstances in which primary medical services may be sub-contracted. Consent of NHS England required to assignment of rights in relation to primary medical services
GC 15.1A	Direction 12 (2) - (4) and 12 (6) – (8)	Regulation 23	Requirements in relation to sub-contracting in relation to clinical matters
GC 18.9.1	Direction 11	Regulation 21	Publication of earnings – to publish mean net earnings of GPs
GC 36	Direction 9	Direction 11 APMS	Disregarding personal financial interests when referring or prescribing
GC 36.2	Direction 53	Regulation 85	Gifts

The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England
- Care Quality Commission
- Health Education England
- The National Institute for Health and Care Excellence
- NHS Improvement
- Public Health England

Our values: clinical engagement, patient involvement, local ownership, national support

www.england.nhs.uk/newbusinessmodels **#futureNHS**